

SAN JOSE MEDICAL CENTER SITE OPTIONS

HEALTH CARE ISSUES

DRAFT FOR PRESENTATION AT THE FORMER SAN JOSE MEDICAL CENTER STAKEHOLDER ADVISORY COMMITTEE MEETING

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I. Context

The abrupt closure of San Jose Medical Center (SJMC) in late 2004 left a gap in health-care services readily accessible to residents of the downtown area. This gap is comprised of:

- (1) General-acute-care beds;
- (2) A trauma center;
- (3) An emergency room;
- (4) Non-emergency outpatient services provided at SJMC; and
- (5) An unknown number of physicians with offices near SJMC that elected (or will in the future elect) to move to locations adjacent to other hospitals.

The plan on the part of SJMC's owners (HCA) was to consolidate services (including the trauma center) at Regional Medical Center, some 2.5 miles away. While from health-planning and economic perspectives this plan makes sense, it still represents a worsening in the status quo for many downtown residents, and for those residents in need of care without ready access to private transportation, it represents a hardship.

II. Needs Prioritized

Of the five components of this gap identified above, the loss of the trauma center should create fewer problems than the loss of other services. A more comprehensive trauma center (Level I) is available at Santa Clara Valley Medical Center, some 7.3 miles away, and the SJMC Level II trauma center was relocated to Regional. Thus, there are two trauma centers within a 7.3-mile radius of the SJMC site.

The loss of general-acute-care beds represents a greater loss than the trauma center, but is of less urgency than the other services comprising the gap. The primary reasons for this are:

- (1) During its last few years of operation, SJMC had an occupancy rate of approximately 33 percent, approximately one third of its patients resided in the downtown area, and among hospitals serving the downtown population, SJMC had the third ranking market share;
- (2) While the downtown population is likely to face a bed shortage in a few years, planned increases at Regional and available beds at O'Connor Hospital and Valley Medical Center could accommodate downtown needs until 2015-2020, assuming beds at all these hospitals are available to all patients, regardless of their financial sponsorship; and
- (3) Most-frequently-used health services are emergency-room visits and other outpatient services, either in hospital outpatient departments, clinics or physicians' offices. The SJMC emergency room and outpatient clinic no longer exist and many physicians have relocated to the Regional or O'Connor campuses.

A major complicating factor in this scenario is Regional's canceling its Medi-Cal contracts with the California Medical Assistance Commission (CMAC), covering the senior and disabled Medi-Cal beneficiaries, and with the Santa Clara Family Health Plan and Blue Cross Medi-Cal plan, covering mainly families and children. Thus, Regional's beds do not replace all those lost from SJMC's closure. Rather than improve the health delivery system, which the promised consolidation could have accomplished, the local delivery system was harmed. Non-emergency Medi-Cal inpatients are now diverted mainly to O'Connor and Valley Medical Center, causing distortions and adverse economic effects. If there is no reasonable promise of a reversal of this status, the consolidation of services and capacity at Regional cannot be considered an adequate substitute for a downtown hospital.

The loss of the emergency medical service at SJMC represents a greater loss to the community than the loss of inpatient capacity. While the emergency rooms at all nearby hospitals are available to patients with emergency medical conditions regardless of payer source, now downtown patients will have to travel a greater distance. An emergency service cannot be freestanding; it must be part of a hospital. Without building a new hospital, the next best thing is establishing an urgent care clinic on or near the SJMC site. To avoid distortions, the clinic must accept Medi-Cal patients, and not discriminate according to payer source when referring patients to hospitals. That is, it should not be allowed to routinely refer Medi-Cal patients to one hospital and private-insurance patients to another.

Non-urgent outpatient capacity is also an important gap to be filled. At a minimum, this would involve a primary-care clinic that accepts all patients in need of

service without regard to payer source. The clinic should include a clinical laboratory and x-ray capabilities. And, as suggested for the urgent care center, its referrals for specialty care and inpatient care should not distinguish between sources of payment. Ideally, the urgent care center and the primary care clinic would be under the same sponsorship, to enable efficient use of ancillary services, such as lab and x-ray. While including specialty care would be beneficial to the community, especially the elderly and chronically ill, establishing a multi-specialty group is a major undertaking.

III. Actions for Consideration

1. The highest priority is establishing a primary care clinic and urgent care center, ideally under the same management and in the same facility. These services must not discriminate on the basis of payer source in both treating patients and referring for specialty and hospital care. This may require a one-time capital subsidy. The need for such a subsidy suggests the SJMC site be zoned for high value development. It should be noted that there is currently an urgent care clinic, Bay Area Urgent Care, located across the street from the hospital site at 696 E. Santa Clara Street. This little-known clinic, however, does not accept Medi-Cal. The recommended primary care and urgent care clinic could be constructed on the hospital site, or could be located off site, for example in the Chavez medical office building at 25 N. 14th Street. This building, however, is in need of updating and refurbishing.

2. The following array of options are listed for consideration, with no specific recommendations offered at this time:

(1) Facilitate development of the primary care and urgent care clinics, on or off site, and allow the remainder of the site to divert to non-health-care development, with the intention of maximizing the value of the site to enable a sufficient subsidy to support the clinic's development.

(2) The City of San Jose exert maximum pressure on Regional Medical Center to negotiate and execute fee-for-service and managed-care Medi-Cal contracts. Over 200 hospitals statewide have such contracts. Given the shortage of capacity in San Jose, Regional should be able to negotiate contract terms that are relatively favorable. Pressure can be exerted through, for example, City Council resolutions, zoning, and insurance plans covering City employees. Full participation in Medi-Cal could be viewed as a cost of doing business in San Jose. A major defect in this approach is that the Medi-Cal payers across the table from Regional during the contract negotiations could gain an unfair negotiating advantage. This is a delicate balancing act.

(3) Designate sufficient space for a small hospital on the current site or at another downtown location, requiring approximately five acres. This could be costly without a hospital operator stepping up soon. The longer the site is vacant, the greater the cost to the owner and to the City. If this

route is taken, the most feasible configuration from a health-system perspective may be construction of a satellite hospital of a large, out-of-area tertiary-level medical center, such as Stanford. It would be a primary-care hospital for the community and a “feeder” to the medical center. It is doubtful, given the area demographics and the payer mix, that a freestanding hospital is feasible. This could be a high-risk option, however. First, no major hospital has come forward expressing interest. Second, if one did, it could force Regional to abandon its expansion and seismic upgrade plans, which could force it out of business by 2013-15. And third, after forcing Regional to abandon its plans, the potential new hospital could also abandon its plans, making an already bad situation worse.